**XYZ Corporation**

**Group Wrap Plan Document**

**Established as of 1/1/2016**

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**ARTICLE 1: GENERAL PROVISIONS AND DEFINITIONS**

**Section 1.1 - Purpose and Rules**.

XYZ Corporation (the "Company") hereby establishes the XYZ Corporation Employee Benefits Plan (the "Plan") to provide health and welfare benefits ("Programs") to its eligible employees and their beneficiaries. The welfare benefits provided through this Plan are for the exclusive benefit of participating employees and their eligible beneficiaries, and any assets of the Plan shall be held for the exclusive purpose of providing such welfare benefits to the Plan's participants and their beneficiaries and for defraying the reasonable expenses of administering the Plan.

The Plan incorporates by reference the plan documents, summary plan descriptions, insurance contracts, benefit schedules, and other service contracts for the Programs listed in Schedule A, copies of which are attached hereto ("Incorporated Documents"). The Incorporated Documents contain the substantive provisions governing benefits provided by the Plan. As an Incorporated Document is amended or superseded, the amended or superseded version of the Incorporated Document will automatically (1) replace the existing Incorporated Document, and (2) become incorporated by reference. The Plan Administrator is responsible for maintaining accurate and current copies of all Incorporated Documents, which include contact information for each Program Provider.

The Plan is intended to conform to the written plan document and other requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

**Section 1.2 - Priority of Plan Documents.**

The terms of the Incorporated Documents relating to a particular Program shall take precedence over a conflicting provision of this document, except that the assigned Plan number is 510 for the Plan and all Programs hereunder.

**Section 1.3 - Terms and Definitions**.

**1.3.1 - Effective Date**. "Effective Date" means the original effective date of this document, which is 1/1/2016.

**1.3.2 - Eligible Employee**. "Eligible Employee" means, with respect to any Program, any Employee who meets the definition of Eligible Employee under the terms of such Program. Eligibility criteria is listed in Schedule B.

**1.3.3 - Employee**. "Employee" means a common-law employee of any Participating Employer.

**1.3.4 - Participating Employer**. "Participating Employer" means the Company or any other entity that participates in this Plan with the consent of the Company. An entity's participation in this Plan requires the approval of the Company and of such other entity, which approval shall be evidenced by the updating of Schedule A which identifies Participating Employers. The Company shall be deemed to have consented to the participation of a subsidiary in any Program if, under the terms of any insurance contract or schedule of benefits for such Program, the Company, as either the contracting party or the sponsor of such benefits, has contracted for or provided coverage for such subsidiary's employees. "Participating Employer" includes any successor(s) to a Participating Employer, whether by merger, consolidation or otherwise. All Participating Employers are listed in Schedule A.

**1.3.5 - Plan**. "Plan" means the welfare benefit plan established hereunder, which shall be known as the "XYZ Corporation Employee Benefits Plan."

**1.3.6 - Plan Administrator**. "Plan Administrator" has the meaning assigned thereto under Section 3.1 of this Plan.

**1.3.7 - Plan Sponsor.**  "Plan Sponsor" means XYZ Corporation.

**1.3.8 - Plan Year.**  "Plan Year" means each consecutive twelve month period starting on January 1 ending December 31st.

**1.3.9 - Programs**. "Programs" means the welfare benefits provided to Participants under the Plan which are governed by the terms and conditions contained herein and in the Incorporated Documents.

Once a Participating Employer has adopted this Plan, it is within the discretion of that Participating Employer, with the approval of the Company, to designate the Programs the Participating Employer shall offer to its employees through this Plan. The Programs may be changed or may be supplemented with additional Programs from time to time by the Company.

**1.3.10 - Providers.** "Providers" means the Plan Sponsor for Programs which are self-administered, the insurance company for any Program which is insured, and the third-party administrator for all other Programs.

**ARTICLE 2: TERMS OF THE PLAN**

**Section 2.1 - Eligibility and Participation.**

An Eligible Employee shall become a Participant in the Plan upon satisfying the terms and conditions for participation in one or more Programs. To participate in any particular Program offered under the Plan, an Eligible Employee must satisfy the terms and conditions for participation in such Program. An Employee's eligibility to receive benefits under this Plan shall be dictated by and limited to his or her eligibility to receive benefits under each Program. A person shall remain a Participant in the Plan until he or she ceases to satisfy the terms and conditions for participation in all of the Plan's Programs. A summary of eligibility requirements has been provided in Schedule B.

**Section 2.2 - Enrollment.**

Eligible Employees must complete an application form to enroll themselves and/or their beneficiaries. New Employees must enroll within certain time periods after being hired (or becoming newly eligible to participate in the Plan), as discussed in the Programs and/or enrollment materials provided by the Company. Otherwise, enrollment generally is limited to the annual open enrollment period which occurs before January 1st of each year.

**Section 2.3 - Special Enrollment.**

In certain circumstances, you may be entitled to special enrollment rights which allow you to enroll yourself and/or your eligible spouse or eligible dependents into Programs offered under the Plan outside of the open enrollment period. In general, if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days.

Special enrollment rights may even grant you the ability to change existing coverage that you elected during the open enrollment period, including, but not limited to, the addition or reduction of benefits provided under the Plan. You should refer to the Incorporated Documents issued by each Program Provider to review your special enrollment rights for each benefit provided under the Plan.

**Section 2.4 - Premium Payments.**

Employees must make applicable premium payments and other contributions based on the Programs in which they elect under the Plan. The Company provides a schedule of required premium payments and contributions during open and special enrollment periods, and upon request from a Participant.

**Section 2.5 - Insuring and Funding Benefits.**

Funding for this Plan shall consist of an aggregation of the funding for all Programs. The Company shall have the right to insure any benefits under this Plan or to establish any fund or trust for the holding of contributions or payment of benefits under this Plan, either as mandated by law or as the Company deems advisable. With respect to any Program, the Company may require a Participant to contribute all or a portion of the Program's Participant premium charge (or other per capita cost) as a condition of participation. In addition, the Company shall have the right to alter, modify or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy. In addition, the Company shall have the right to alter, modify or terminate any funding method or methods in existence as of the Effective Date of this Plan.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier. To the extent funds are transferred to or accumulated in a trust to provide any benefit, that benefit will be payable from the assets of such trust. Neither the Company nor any Participating Employer shall have any further responsibility to pay such benefit.

Each Participating Employer shall, upon demand from the Company, reimburse the Company for the Participating Employer's appropriate share of any insurance premiums or funding necessary to provide benefits under this Plan.

**Section 2.6 - Benefits and Termination of Rights to Benefits.**

The benefits available under this Plan shall consist of an aggregation of the benefits available under each Program, including all limitations and exclusions with respect to each Program's benefits.

A Participant's right to benefits under this Plan shall consist of and be limited to his or her right to benefits under each Program in which he or she is a Participant. Any termination or cessation of a Participant's rights or coverage under a Program shall be considered a termination or cessation of those same rights under this Plan. This Plan provides for no rights other than those rights provided for under each Program.

Other circumstances can result in the termination, reduction, recovery or denial of benefits. The Incorporated Documents will provide additional information in regards to these circumstances.

**Section 2.7 - Payment of Benefits.**

The benefits under this Plan shall be payable according to the payment policy of each Program.

**Section 2.8 - Grandfathered Status.**

To the extent that any of the benefits offered under the Plan are deemed to be "grandfathered health plans," and thus exempt from certain provisions of the Patient Protection and Affordable Care Act (PPACA), you will receive a separate written notification from the applicable Program Provider with more specific details on how your coverage for that particular benefit is impacted by its grandfathered status.

**Section 2.9 - Procedures for the Submission and Review of Claims.**

**2.9.1 - In General**. In general, claims procedures for each Program offered under the Plan are outlined in the Incorporated Documents that are attached hereto. At minimum, each health and welfare plan must conform to certain standards as set forth in Section 503 of ERISA. This includes the establishment and maintenance of reasonable claims procedures such as those governing the filing of benefit claims, notification of benefit determinations, and the appeal of adverse benefit determinations.

**2.9.2 - Filing a Claim**. A person entitled to benefits by any Program offered under the Plan (a "Claimant") must generally file a claim in writing (except for urgent care claims which can be submitted orally) in accordance with the Program Provider's claim filing guidelines.

**2.9.3 - Prior Approval**. The details surrounding any Program which requires prior approval to receiving a benefit, including, but not limited to, preauthorization procedures or utilization review procedures, will be outlined in the Incorporated Documents for each applicable Program.

**2.9.4 - Authorized Representative.** Plan Participants may designate an authorized representative to act on their behalf provided the authorization is done so in writing and submitted to the applicable Program Provider. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of a Participant's medical condition may act as the authorized representative even if there is no prior authorization.

**2.9.5 - Timing of Notice of Claim**. Each Program Provider will provide notification to the Claimant of benefit determination within a reasonable time period, but never later than the timeframe below for claims involving urgent care, concurrent care, pre-service care or post-service care.

**Urgent Care**. In the case of a claim involving urgent care, the Plan Administrator (or Program Provider) shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator (or Program Provider) shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator (or Program Provider) shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the Plan's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.

**Concurrent Care**. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

A. Any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator (or Program Provider) shall notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

B. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator (or Program Provider) shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Pre-service claims**. In the case of a pre-service claim, the Plan Administrator (or Program Provider) shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator (or Program Provider) both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

**Post-service claims**. In the case of a post-service claim, the Plan Administrator (or Program Provider) shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator (or Program Provider) both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

**2.9.6 - Disability Claims**. In the case of a claim for disability benefits, the Plan Administrator (or Program Provider) shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator (or Program Provider) both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator (or Program Provider) determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator (or Program Provider) notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

**2.9.7 - Other Claims**. If a claim is wholly or partially denied, the Plan Administrator (or Program Provider) shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Plan Administrator (or Program Provider) determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator (or Program Provider) determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

**2.9.8 - Notice of Denied Claim**. If a claim is wholly or partially denied, the Plan Administrator (or Program Provider) will provide the Claimant with a notice identifying (1) the reason(s) for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he or she wishes to appeal the denial, including a statement that the Claimant may bring a civil action under ERISA.

In addition to the above information, if a claim providing disability benefits is wholly or partially denied, the following information must be included with the notice described above:

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination by a Program concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the Claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

**2.9.9 - Claims Appeals**. The procedure to be followed for reviewing claims under this Plan shall correspond to the claims review procedure for the Program under which the claim was originally submitted. Unless the Plan Administrator or other authorized party (e.g., insurance carrier) publishes a different procedure for reviewing claims under a Program, the claims review procedure for that Program shall be as follows:

a) Within 180 days (or 60 days in the case of claim involving a disability benefit) of the notice of denial or partial denial of a claim, a written request for a review shall be submitted to the Plan Administrator clearly identifying the claim and the reason or reasons for the request.

b) If after review the Plan Administrator (or Program Provider) continues to deny the validity of the claim in full or in part, the Plan Administrator (or Program Provider) will notify the Claimant of its decision in writing. Such writing shall be in a form designed to be understood by the Claimant and will contain:

i. The specific reason or reasons for the denial;

ii. A specific reference to pertinent Plan provisions;

iii. A description of any additional materials or information necessary for such Claimant to perfect the claim and an explanation of why such material or information is necessary; and

iv. Information as to the steps to be taken if the Claimant wishes to appeal the decision.

Such notification will be given by the Plan Administrator (or Program Provider) within 60 days after the complete appeal is received by the Plan Administrator (or Program Provider), or within 120 days if the Plan Administrator (or Program Provider) determines special circumstances require an extension of time for considering the appeal, and if written notice of such extension and circumstances is given to the Claimant within the initial 60 day period.

c) No action at law or in equity may be brought by any person to recover benefits claimed hereunder unless and until an appeal for such denied benefits has been brought and denied (or is deemed denied) in accordance with the foregoing procedures.

d) The Plan claim procedures shall at all times comply with 29 CFR 2560.503-1, as amended from time to time.

**2.9.10 - External Review Process**. Under certain circumstances, you may have the right to obtain an external review, which is a review that is conducted by someone or some entity outside of the Plan. In general, you have 16 consumer protection standards available:

1. The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

2. Issuers (or plans) must be required to provide effective written notice to Claimants of their rights to external review.

3. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if - (a) the issuer (or Plan) waives the exhaustion requirement; (b) the issuer (or Plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.

4. The cost of an independent review organization (IRO) to conduct an external review must be borne by the issuer (or Plan), although the process may require a nominal filing fee from the Claimant requesting external review.

5. There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.

6. The process must allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

7. The IRO must be assigned by the State or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process (such as rotational assignment), and in no event assigned by the issuer, the Plan, or the individual.

8. The process must provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the health care service that is the subject of the review.

9. Approved IROs must have no conflicts of interest that will influence their independence.

10. Claimants must be allowed to submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the Claimant must be notified of the right to submit additional information to the IRO; the IRO must allow the Claimant at least 5 business days to submit any additional information and any additional information submitted by the Claimant must be forwarded to the issuer (or Plan) within one business day of receipt by the IRO.

11. The IRO decision must be binding on the Claimant, as well as the Plan or issuer (except to the extent that other remedies are available under State or Federal law).

12. For standard external review, the IRO must provide written notice to the issuer (or Plan) and the Claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review.

13. The process must provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).

14. Issuers (or Plans) must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to Participants, beneficiaries, or enrollees, substantially similar to section 17 of the NAIC Uniform Model Act.

15. The IRO must maintain written records and make them available upon request to the State, substantially similar to section 15 of the NAIC Uniform Model Act.

16. The process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act.

Refer to the Incorporated Documents which are attached for additional information on your rights to an external review.

**2.9.11 - Other Circumstances.** Other circumstances may result in the loss, disqualification, ineligibility, denial, forfeiture, suspension, offset, reduction, or recovery of any benefit that a Participant might otherwise expect the Plan to provide. You should refer to the Incorporated Documents for more specific details.

**Section 2.10 - Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act).**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending medical provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a medical provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Section 2.11 - Women's Health and Cancer Rights Act (WHCRA).**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

* All stages of reconstruction of the breast on which the mastectomy was performed;
* Surgery and reconstruction of the other breast to produce a symmetrical appearance;
* Prostheses; and
* Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your Program Provider at the number provided in the applicable Incorporated Document.

**Section 2.12 - Minors and Legally Incompetent Individuals.**

If a payment or reimbursement is to be made on behalf of a person who is either a minor or legally incompetent individual, the Plan Administrator (or Program Provider) may direct that such payment or reimbursement is to be made to the legal guardian of that individual.

If a payment or reimbursement is to be made to a minor and there is no legal guardian, the Plan Administrator (or Program Provider) may direct payment or reimbursement to a responsible adult with whom the minor maintains his residence, or to the custodian of the minor under the Uniform Transfer to Minors Act, as long as this is permitted by state law in accordance with the state in which such minor resides.

**Section 2.13 - Continuation Coverage.**

All persons whose health benefits would otherwise terminate due to a qualifying event described in Title X of the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), as codified in Code Section 4980B and as amended and as interpreted under related administrative regulations, may have rights to Continuation Coverage at their own expense. To the extent that the law or regulations require Continuation Coverage under this Plan:

a) Any Participant who becomes eligible for Continuation Coverage shall be notified of such eligibility within the period of time that is the maximum allowed by law;

b) All periods of coverage or elections shall be for the minimum required by law; and

c) Premiums shall be chargeable at the maximum rate allowed by law.

The Plan Administrator shall establish policies and procedures necessary to maintain the Plan's compliance with COBRA and any applicable state law.

**Section 2.14 - FMLA.**

To the extent the Plan (or any Program offered under the Plan) is subject to the Family Medical Leave Act (FMLA), the Plan Administrator shall comply with such applicable law and will permit a Participant taking unpaid leave under the FMLA to continue medical benefits. Participants who elect to continue coverage during the leave will be required to make payments for such coverage under a method determined by the Plan Administrator and permissible by law.

If a Participant revoked coverage while on FMLA leave, coverage will be reinstated to the extent required by Treas. Reg. 1.125-3. Participants are not entitled to payment or reimbursement for claims during any time period in which coverage is terminated.

Programs which are not subject to FMLA may be continued according to a policy established by the Company and are not addressed in this Plan document.

**Section 2.15 - USERRA.**

The Plan Administrator will permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and shall also comply with reinstatement rights under such law.

**Section 2.16 - HIPAA Portability.**

To the extent the Plan (or any Programs offered under the Plan) constitute a group health plan as defined in Treas. Reg. section 54.9801-2, or the Plan Administrator makes a determination that the Plan is subject to the portability rules of the Health Insurance Portability and Accountability Act (HIPAA), the Plan shall comply with the requirements of Code section 9801.

**ARTICLE 3 - ADMINISTRATION**

**Section 3.1 - Plan Administrator.**

The Company shall be the Plan Administrator (unless it appoints one or more persons to that position). The Company's federal taxpayer identification number is 20-1590762. Said Plan Administrator shall administer this Plan and the Programs and shall be the "named fiduciary" for this Plan and the Programs. Nothing herein shall restrict the Company's right to remove a Plan Administrator at any time.

The Plan Administrator shall have control of the day-to-day administration of this Plan and the Programs, and shall serve without additional remuneration if an employee of the Company, except for reimbursement of out-of-pocket expenses, and for so long as it is mutually agreeable to the Plan Administrator and to the Company. If the Company appoints one or more persons as Plan Administrator, it shall have no duty or responsibility with respect to the administration of this Plan and the Programs other than the appointment or removal of the Plan Administrator.

**Section 3.2 - Duties and Powers of the Plan Administrator.**

The Plan Administrator shall have the following duties, responsibilities and authority with respect to the administration of this Plan and the Programs:

a) Complete discretionary authority to construe and interpret this Plan and the Programs including, without limitation, determining an employee's eligibility to participate in and receive benefits under one or more Programs, correcting any defect, supplying and omitting and reconciling any inconsistency;

b) To prescribe uniform procedures to be followed by Eligible Employees and Participants in making elections, filing claims, and any other administrative procedure necessary to properly administer any or all of the Programs;

c) To prepare and distribute information explaining this Plan and the Programs to Eligible Employees and Participants;

d) To receive from the Company, the Eligible Employees and Participants such information as may be necessary or desirable for the proper administration of this Plan and the Programs;

e) To employ such persons, including, but not limited to, actuaries, accountants, claims administrators, and counsel, as he or she deems appropriate, to perform such duties as may from time to time be required either by administrative convenience or necessity or under ERISA (and the regulations thereunder) or under the Internal Revenue Code (the "Code") (and the regulations thereunder) and to render advice upon request with regard to any matters arising under this Plan or the Programs;

f) To prepare and file any reports or returns with respect to this Plan and the Programs required under applicable law;

g) To take all other steps deemed necessary or appropriate to properly administer this Plan and the Programs in accordance with their terms and the requirements of applicable law; and

h) To act in accordance with all applicable laws governing fiduciary standards.

To the extent that the administrative procedures or duties of the Plan Administrator conflict with the provisions of any Incorporated Documents under which Plan benefits are provided, the Incorporated Documents shall govern. The Plan Administrator (in that capacity) shall have no power to terminate this Plan or the Programs.

**Section 3.3 - Qualified Medical Child Support Orders.**

The Plan Administrator shall establish reasonable procedures to determine whether medical child support orders (as defined in ERISA section 609(a)(2)(B)) are qualified medical child support orders (as defined in ERISA section 609(a)(2)(A)) and to administer the provision of benefits under such qualified orders. Such procedures:

a) Shall be in writing;

b) Shall provide for the notification of each person specified in a medical child support order as eligible to receive benefits under the Plan (at the address included in the medical child support order) of such procedures promptly upon receipt by the Plan of the medical child support order; and

c) Shall permit an alternate recipient (as defined in ERISA section 609(a)(2)(C)) to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order.

**Section 3.4 - Rules and Decisions.**

The Plan Administrator shall decide any matter, and may adopt any rule or procedure, regarding eligibility, benefits, claims, or any other issue arising under this Plan that he or she deems necessary, desirable or appropriate in the administration of this Plan and the Programs, including factual determinations. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Eligible Employees and Participants in similar circumstances and shall be conclusive and binding on all persons having an interest in this Plan or any Program. When making any decision or determination, the Plan Administrator shall be entitled to rely upon, without further inquiry, such information as may be furnished to him or her by an Eligible Employee or Participant, the Company, legal counsel, or the administrator of any Program or another plan.

**Section 3.5 - Delegation and Allocation of Responsibility of the Plan Administrator.**

The Plan Administrator may allocate or delegate any responsibility regarding this Plan and/or the Programs provided to him or her under the Plan among one or more persons, which persons may be either named fiduciaries or persons other than fiduciaries. Any such allocation or designation shall be in writing, in the record of this Plan and the Programs, and shall:

a) Specifically identify the person or persons to whom a responsibility is allocated or delegated; and

b) Specifically identify the nature and scope of the responsibility allocated.

The named fiduciary or other person to whom a responsibility of the Plan Administrator is allocated or delegated shall be responsible only for the performance of that responsibility according to the terms of the delegation or allocation, and, in accordance with Section 405(a) of ERISA, such person shall not be liable for the act or omission of any other person with respect thereto unless:

a) By his or her failure to properly administer the specific responsibility he or she has enabled such other person to commit a breach of fiduciary responsibility; or

b) He or she knowingly participates in, or knowingly undertakes to conceal, an act or omission of another person, knowing such act or omission to be a breach; or

c) Having knowledge of the breach of another, he or she fails to make reasonable efforts under the circumstances to remedy said breach.

Any person or group of persons may serve in more than one fiduciary capacity with respect to this Plan and/or the Programs.

**Section 3.6 - Representations to Fiduciaries.**

Any person who is a fiduciary with respect to this Plan and/or the Programs shall be entitled to rely on representations made by Eligible Employees, Participants, Employees, former Employees, and beneficiaries with respect to age, marital status and other personal facts, unless said fiduciary has actual knowledge that said representations are false.

**Section 3.7 - Indemnity.**

The Company and each Participating Employer agree to jointly and severally indemnify and hold harmless the Plan Administrator and any Employee acting in such capacity against any and all expenses and liabilities arising out of his actions or failure to act in such capacity, excepting only expenses and liabilities arising out of his own willful misconduct or gross negligence. This right of indemnification is in addition to any other rights to which the Plan Administrator or any such Employee may be entitled. Liabilities and expenses against which the Plan Administrator or Employee is indemnified include, without limitation, the amount of any settlement or judgment, costs, counsel fees and related charges reasonably incurred in connection with a claim asserted or proceedings brought against him or the settlement thereof.

**ARTICLE 4: AMENDMENT OR TERMINATION**

**Section 4.1 - Amendment or Termination.**

The Company shall have the sole right to alter, amend or terminate this Plan and/or Programs, in whole or in part, at any time it determines to be appropriate, without notice and without the consent of any Participating Employer, Participant, any Participant's spouse, dependents or beneficiary or any other person. To the extent permitted by law, the Plan may be amended retroactively. The Company may amend or substitute any set of Program terms without affecting other Plan provisions.

**ARTICLE 5 - PARTICIPANT RIGHTS AND RESPONSIBILITIES**

**AND LIMITATIONS THEREOF**

**Section 5.1 - No Enlargement of Employee Rights.**

Nothing contained in this Plan or the Programs shall be deemed to give an Eligible Employee, Participant, or employee of the Company or any Participating Employer the right to be retained in the service of the Company or Participating Employer or to interfere with the right of the Company or Participating Employer to discharge or retire such person at any time.

**Section 5.2 - No Assignment.**

Except as may otherwise be specifically provided in this Plan, the Programs, the insurance contracts, or applicable law, a Participant's rights, interests or benefits under this Plan or the Programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Programs, and any such attempt shall be void.

**Section 5.3 - Notice of Address.**

Each person entitled to benefits under one or more Programs must file with the Company, in writing, his or her mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of this Plan and the Programs, and there shall be no obligation on the part of the Company, the Plan Administrator (or his or her delegate), or any insurer to search for or to ascertain the location of such person.

**Section 5.4 - Plan Contact Information.**

**5.4.1 - Plan Sponsor and Plan Administrator.**

The contact information of the Plan Sponsor and Plan Administrator is listed below.

XYZ Corporation

Attention: Jane Smith

379 East University Avenue

Provo, UT 84606

801-555-0000

**5.4.2 - Agent of Service for Legal Process**. The agent of service for legal process shall be the Director of Human Resources of the Plan Sponsor. Service may also be made upon the Plan Administrator or anyone the Company has delegated to act on behalf of the Plan Administrator.

**ARTICLE 6 - GOVERNING TERMS AND APPLICABLE LAW**

**Section 6.1 - Severability.**

If any provision of this Plan or any Program is be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

**Section 6.2 - Corporate Actions.**

Any action required to be taken by the Company or a Participating Employer under this Plan may be taken by any officer of the Company or a Participating Employer acting under authority of the board of directors, as constituted from time to time, or comparable governing body charged with management of the organization, unless otherwise specified or delegated.

**Section 6.3 - Application of State Law.**

This Plan shall be administered, construed, and enforced according to the laws of the State of Utah and in courts situated in that State, except as preempted by ERISA.

**Section 6.4 - HIPAA Privacy.**

The Plan is required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to take adequate steps to protect any individually identifiable health information to the extent that such information must be kept confidential by law.

**Section 6.5 - Taxation.**

The Company intends, but does not guarantee, that all benefit payments and reimbursements under this plan are not taxable under federal tax law. However, any payments or reimbursements received under a Program which provides income replacement, such as a short-term or long-term disability insurance policy, may become subject to federal taxes (and other taxes) if premiums for those Programs are paid with before tax dollars. Plan participants should refer to the Incorporated Documents and consult their professional tax advisor to determine the tax consequences of participation in this Plan, as the Company cannot guarantee that any particular income tax (federal, state, or local), payroll tax, personal property tax or other tax will result from receiving payments or reimbursements under this Plan.

**ARTICLE 7 - STATEMENT OF ERISA RIGHTS**

**Section 7.1 - Your Rights.**

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as a participant in the Plan. ERISA provides that all Plan participants shall be entitled to:

**I. Receive Information About Your Plan and Benefits**

Examine, without charge, at XYZ Corporation’s principal office and at other specified locations, such as worksites, all documents governing the Plan, including any Program Provider documents, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Human Resources Director of XYZ Corporation, copies of documents governing the operations of the Plan, including any Program Provider contracts and copies of the latest annual report (Form 5500 Series), if any, and the summary plan description (SPD). XYZ Corporation may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case XYZ Corporation, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

**II. COBRA and HIPAA Rights**

To the extent the Plan (or any Programs offered under the Plan) are subject to COBRA, you will have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

To the extent the Plan (or any Programs offered under the Plan) impose any exclusionary periods of coverage for preexisting conditions under your group health plan(s), you may have the right to have those exclusionary periods reduced or eliminated. Refer to each Program Provider document to determine if an exclusionary period applies, and how you may be able to go about reducing or eliminating those exclusionary periods.

**III. Prudent Actions by Plan Fiduciaries**

ERISA imposes duties upon the person(s) who are responsible for the operation of the Plan. The person(s) who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

**IV. Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights.

For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require XYZ Corporation, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in the Claims Procedures section of this document), you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person(s) you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**V. Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Human Resources Director of XYZ Corporation. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**ARTICLE 8 - EXECUTION OF PLAN**

**Section 8.1 - Plan Adoption.**

XYZ Corporation hereby establishes the Plan effective 1/1/2016 to provide health and welfare benefits to its Eligible Employees and their eligible beneficiaries. This Plan is intended to qualify as a welfare benefit plan of the Company under ERISA.

As an authorized representative of the Plan Sponsor, the signature below shall constitute the full execution of the Plan, as well as the Plan documentation requirements under ERISA §402.

Signature of authorized representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of authorized representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job title of authorized representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCHEDULE A**

XYZ Corporation Employee Benefits Plan

As of 1/1/2016

Participating Employer(s).

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examples of Programs Offered:

Direct Care Administrators Self Funded Medical Plan Medical

Select Health Select Health Managed Care Medical

Aetna Inc. Business Travel Accident Business Travel Accident

Dentist Direct Administrators Dental PPO Dental

Vision Care Services Vision Care Vision

Unum Basic Group Life/AD&D Life/AD&D

Unum Long-Term Disability Disability

Unum Short-Term Disability Disability

Unum Individual Disability Income Disability

Unum Group Accident Accident

Xeos Solutions Health Flexible Spending Account Health FSA

Xeos Solutions Dependent Care FSA Dependent Care FSA

Xeos Solutions Health Savings Account Health Savings Account

Xeos Solutions Health Reimbursement Arrangement HRA

Xeos Solutions HRA Aggregated Special HRA Special

Partners RX Speciality Drug Plan Drug

TruHearing Speciality Hearing Plan Hearing

Green Light Nexus Speciality Re-Pricing Claims Plan Medical

LegaLees Premium Only Plan Premium Only Plan (POP) Premiums

Transamerica Voluntary Group Term Life Term Life

Transamerica Voluntary Universal Life/Annuities UL/Annuities

Unum Dependent Term Life Term Life

**SCHEDULE B**

**Requirements for Employee Eligibility.**

To be an eligible employee you must meet the following criteria:

1. You must be an employee; and

2. You must satisfy the minimum hours of service requirement of 30 or more hours of service per week (averaged on an annual basis); and

3. You must complete a probationary period for newly hired employees (or newly eligible employees) that ends on the first of the month following date of employment

**COBRA General Notice**

**Important Note:**

This COBRA General Notice only applies to the extent the Plan (or any Programs offered under the Plan) are subject to the COBRA provisions. If COBRA does not apply, you may have continuation coverage rights under other laws, such as applicable state law.

**Introduction**

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**  When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage**. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

**What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

* Your hours of employment are reduced, or
* Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

* Your spouse dies;
* Your spouse's hours of employment are reduced;
* Your spouse's employment ends for any reason other than his or her gross misconduct;
* Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
* You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

* The parent-employee dies;
* The parent-employee's hours of employment are reduced;
* The parent-employee's employment ends for any reason other than his or her gross misconduct;
* The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
* The parents become divorced or legally separated; or
* The child stops being eligible for coverage under the Plan as a "dependent child.”

If you are covered under a retiree plan, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to XYZ Corporation and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

* The end of employment or reduction of hours of employment;
* Death of the employee;
* Commencement of a proceeding in bankruptcy with respect to the employer if the Plan provides retiree coverage; or
* The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Human Resources Manager.**

**How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

**Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan contact information**

XYZ Corporation

XYZ Corporation

Attention: Jane Smith

379 East University Avenue

Provo, UT 84606

801-555-0000

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.